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THE *Cleveland* DENTAL
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Oral Hygiene

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The Governor's Secretary.....	1314
<i>Joseph H. Steele, D.D.S.</i>	
The Dental Chronicles of the Indigent	1319
Have You a Picture?.....	1324
The Question Is.....	1325
<i>W. A. Moline, D.M.D.</i>	
What is a Dental Hygienist?.....	1330
<i>Margaret Jeffreys, R.D.H.</i>	
Michigan Examines.....	1336
The Bum's Rush.....	1340
<i>Frank A. Dunn, D.D.S.</i>	
Editorial Comment.....	1346
Dear Oral Hygiene.....	1348
Ask Oral Hygiene.....	1350

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THE GOVERNOR'S SECRETARY

by JOSEPH H. STELE, D.D.S.

I WENT TO TRENTON a few weeks ago to see the Administrative Secretary to Governor Hoffman, of New Jersey. Someone had discovered that he was a dentist.

I found him at the end of a long corridor lined with the portraits of distinguished men—the six New Jersey signers of the Declaration of Independence and the line of governors who had served since Revolutionary days. I entered the Governor's office fully expecting to find the Secretary a derby-hatted, cigar-chewing man with a well seasoned vocabulary who kept his feet comfortably adjusted on the polished surface of his desk. I was entirely unprepared for the type of person who rose to greet me. He did not look like a politician. He did not talk like one. After suggesting pleasantly that I should be seated, he started the interview. As I answered his questions, I kept reminding myself that the situation was rapidly being reversed. I had intended to ask the questions. Instead, I was giving the Secretary the story of my life. Finally, a pause in the conversation gave me an opening. By being mildly insistent I was able at last to persuade Doctor Francis Leo Golden to talk about himself.

He told me that he had been born thirty-six years ago in Jersey City and grew up in a section called the Morris Canal district. Its reputation was not even slightly anemic, according to Doctor Golden. He remembers it as a place "where the canary birds barked back at the bulldogs and everyone wore vulcanized underwear."

Doctor Golden emerged from it to enter, first Georgetown University and then Tulane from which he was graduated as a dentist in 1922. Knowing the dangers of inexperience in his home circuit, he opened his first office in Newark. After two years there, he felt confident enough to return to Jersey City where he remained for ten years.

To earn money in his undergraduate days he had worked as a newspaper correspondent on the *Washington Times*, the *New Orleans States-Item*, and the *New York American*. On the latter he served as a feature writer interviewing genius after genius who was either the sponsor or the inventor of some new fangled "ism." He collaborated with Gene Fowler on a series of burlesque detective stories featuring "Arson Clews," the demon sleuth. He wrote a

daily box called "Stars and Stripes" composed of quips and witty sayings which appeared on the *New York American's* editorial page. But, he had his dental degree and was determined to make use of it. He resigned his newspaper work carrying with him into his dental office a potent symbol of his past—a typewriter presented to him by his employer. The virus of the "writing phobia" continued to work in him. It wasn't long before the sight of the typewriter began to taunt him. He caught himself wanting to leave his patients to pound out a story. Finally a violent form of the disease gripped him and an opportunity for relief presented itself at the same time.

Opposes "Machine"

At this period the political situation in Jersey City was completely dominated by what is familiarly known as a "machine." It controlled everything, to the annoyance of Doctor Golden who had considerable interest in good government. He decided to do something about it. He still remembered the peculiar argot of his home precinct. Therefore, using the language of the Morris Canal district, he wrote a letter to the editor of the *Jersey (City) Journal* and signed it F. L. G. He wrote another letter and that found its way into print too. Soon he was writing two brisk letters a week satirizing the political situation. And the letters were read by an entirely appreciative and

applauding audience that increased rapidly. Finally the "machine" had its attention drawn to these unseemly, heretical outbursts. "These letters must be stopped!" was the command from on high. They continued. Then the "Boss," instead of sending any of his hirelings, stormed into the offices of the publisher and demanded that he stop publishing these letters at once. A violent argument resulted. The upshot of it all was that F. L. G. was offered a contract to conduct a column under his own signature. Then the fun began.

Nineteen twenty-eight was an important gubernatorial election year. The contest was between Morgan Larson and William Dill. The efforts of F. L. G. and his column were largely responsible for the defeat of the latter candidate. Then came the municipal election of 1929. The life of the "machine" was being threatened. Calmly F. L. G. trained his artillery of sharp wit and keen satire on it. The "machine" fought back desperately and, by the use of an unscrupulous coup, managed to squeeze through on a small majority. It was during this campaign that F. L. G. refused a place on the opposition ticket. He stayed on the *Jersey Journal* until 1930. Then it became a question of dentistry as against politics and journalism. The scales swung toward dentistry. Meanwhile, through the efforts of mutual friends and through the medium of his column, he had made the acquaintance of Harold G. Hoff-

man. Their friendship developed rapidly.

Returns to Dentistry

During the next four years Doctor Golden devoted himself exclusively to dentistry, and during that period he was confronted many times by the problem of restriction in carrying on extra-office activities that any dentist falls heir to the moment he opens an office.

As a dental student he had had the extraordinary opportunity of knowing and studying with Doctor C. Edmund Kells¹ and, as a student of literary composition, he had become acquainted with George Randolph Chester, the creator of the "Get Rich Quick Wallingford" stories. Though in widely divergent fields, both were thinking men and F.L.G. remembered and put into practice many things they had taught him. It was Doctor Kells who epitomized his own career with this cryptic thought: "It's later than you think." F.L.G. adopted this as part of his philosophy of living.

With that line in mind, F. L. G. disposed of his dental practice when Harold G. Hoffman insisted that he become director of the gubernatorial election campaign. The success of F. L. G. in that project is history. In the face of the efforts of the powerful "machine" and in an unprecedented Democratic landslide, Harold G. Hoffman, a lone Republican, was elec-

ted Governor. He immediately appointed F. L. G. as his Administrative Secretary. His desk now stands not ten feet from the Governor's. Above it hangs the portrait of the greatest Governor that New Jersey ever had; the one who left this office to become one of our Presidents and to form with Washington and Lincoln our triumvirate of leading Presidents—Woodrow Wilson. In this room, you will remember too, much of the drama surrounding the kidnapping of Charles Lindbergh, Jr. was enacted.

This is no pork-barrel job that the Administrative Secretary has. He is the liason officer between the Governor and sixty-three state agencies. It is imperative that he have the functions of these departments at his finger tips. Aside from this he has to act as a conciliator, to see many of those persons who insist that no one but the Governor can hear their pleas.

An Enveloping Hobby

Most of us have a hobby or an avocation that we discover or create to occupy our leisure. Suddenly we may find that the hobby has begun to absorb most of our time and interest. That was what happened to F. L. G. He found politics and writing about it a pleasant avocation that rapidly turned into his life work. Especially the writing end of it. At present—just to take care of the brief space of time not given to his secretarial duties—he is revising for publication a textbook on the

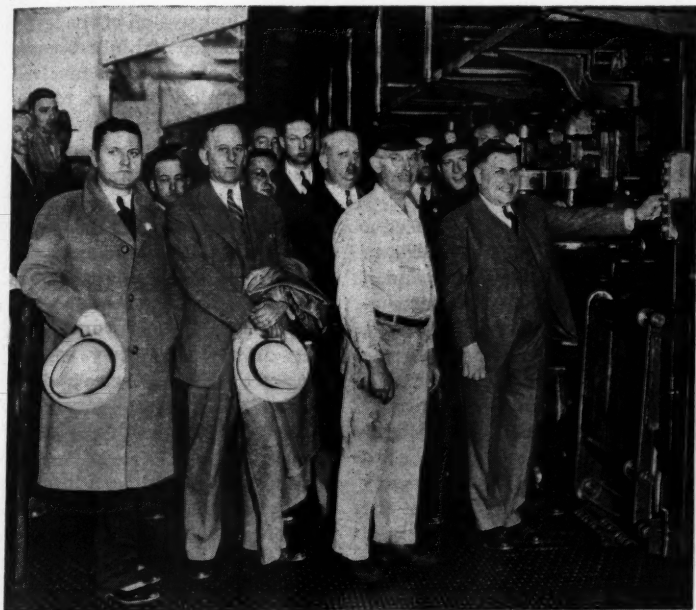
¹An intimate study of the late C. Edmund Kells, D.D.S., by Doctor Golden will appear in a forthcoming issue of ORAL HYGIENE.

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Francis L. Golden, D.D.S., (extreme left, front row). Governor Harold G. Hoffman (extreme right). Photo taken while visiting "Daily News" plant in New York City.

psychology of political procedure tentatively entitled, "Come On Into Politics."

His writings are not confined to the political field. He has written many short stories and articles. Among them are: *TO MAINTAIN THIS ECSTASY*, a story in a satirical vein published in *Esquire*; *NOTES ON BEING A BOSS*, in *Coronet*; *MIRIAM'S THE BERRIES*, in *The Banker's Magazine*; and *MR. PALLSTON HAS A TOOTHACHE*² in *ORAL HYGIENE*. Besides these contributions he is working on a

romantic novel of the Colonial era, research for which required reading and card-indexing data from 286 history books. To top this off he is writing an autobiographical novel called "Without Regrets." Then F. L. G. has had time to be a member of the Delta Sigma Delta fraternity, member of the Hudson County and New Jersey State dental societies and the American Dental Association, and he is a Captain in the Dental Corps and the New Jersey National Guard.

When Doctor Golden talks about Governor Hoffman, there is no limit to his enthusiasm. As

²Golden, F. L.: *Mr. Pallston Has a Toothache*, *ORAL HYGIENE* 27:1043 (August) 1937.

I listened to him, the Governor gradually emerged as a maligned and misunderstood person, a man who is sacrificing everything in the interests of fair government.

Doctor Golden was not so enthusiastic when he talked about the dentists.

"We dentists," he said, "need a guardian, an economic guardian. We spend valuable hours and a great sum of money in perfecting our service and technique, and yet, we deny ourselves the right to acquaint the public with our talent. Organized dentistry should have some Public Relations Counselor, such as baseball has in Judge Landis, such as any big corporation has. Why let the press misinterpret our aims and ideals?"

"That sounds interesting," I said, "but to get back to New Jersey, what is being done for dentists here?"

"Government can do little for us unless we rise from our hypnotic coma and do something for ourselves," he said. "If we don't we will eventually be left completely out in the cold."

"In the last session of the legislature some 250 odd bills became laws. Each one of them involved the subtraction of part of the commodity dollar. Not one of them provided for the dentist to get a part of that commodity dollar too. It seems that, after everyone has secured his share, the dentist will have to make the best out of the scraps that are left. And in the next session when those scraps are discovered (and they always are) they will be allotted to other agencies and the dentist will get even less if he doesn't do something drastic about it."

Doctor Golden himself is sponsoring an act which, if it can get support and become a law, will enable the dentist to obtain a part of that elusive dollar.

On this note the interview ended, leaving me with the impression of a sincere and conscientious man. I had gone to Trenton expecting to meet a politician and I had found an idealist.

*Three Anderson Avenue
Fairview, New Jersey*

The Dental CHRONICLES *of the* INDIGENT

RATHER THAN continue to deal in vague generalities regarding the dental conditions of families on relief, Doctor Leon R. Kramer, Director of the Division of Dental Hygiene, Kansas State Board of Health, decided early this year to make a study of more than 100 families on relief in Marshall, a typical county in Kansas. In this careful survey Doctor Kramer had the enthusiastic support and cooperation of the local dentists, the poor commissioner, and the county commissioners of Marshall County, Kansas.

In planning the study Doctor Kramer kept three things in mind. He wanted, first of all, an impartial record of mouth conditions of adults and children on relief with a view to developing a workable plan for remedial dental service for them. Next, he sought to learn what effect a restricted diet and unsatisfactory economic conditions might have had on the mouths of these people. He also wanted to have smears taken of each mouth to determine the prevalence of communicable disease organisms.

According to the plan developed, one week was designated for the examinations, and a clinical set-up was arranged in a public building in each of seven towns in Marshall County. Then

the poor commissioner wrote to each family on relief and told them to report at a certain hour of a specified day in the town named for mouth examinations. After the completion of the work, all the original records were placed in the files of the poor commissioner's office, available to any group for ready reference.

The families on relief were divided into three age groups. In the first, or pre-school group, 60 children were examined; 35 per cent of the children, ages 3 to 5 inclusive, had dental defects. A

60 PRE-SCHOOL CHILDREN



total of 254 children of school age were examined. Of these 79 per cent were found to have defects; 14.7 per cent showing the presence of Vincent's infection. Ninety per cent of the 242 adults' teeth were defective, and 22 per cent gave indications of Vincent's infection.

Among the pre-school children only one was found who had had any previous dental services. The number of cavities in this group was 10 per cent higher than the average, and the number of abscessed teeth was considerably higher than in similar age groups living on a higher economic level. One of the children had six abscessed teeth. Her mother, when questioned, said the child was high strung and irritable, would eat only soft foods, and always complained of her stomach.

In this connection Doctor Kramer¹ has made an interesting statement in a recent article concerning the tendency of teeth to develop abscesses at an early age. His comment was: "About seven and one half of the deciduous teeth of the average child will decay between the ages of two and one-half and twelve, of which three and seven-tenths will form abscesses. Abscessed teeth are particularly formidable between the ages of three and one-half and seven, owing to the length of the roots and their relation to the germs of the permanent teeth and the copious blood supply."

¹Kramer, L. R.: The Dental Aspect of Public Health, J. A. D. A. 24:1371-77 (August) 1937.

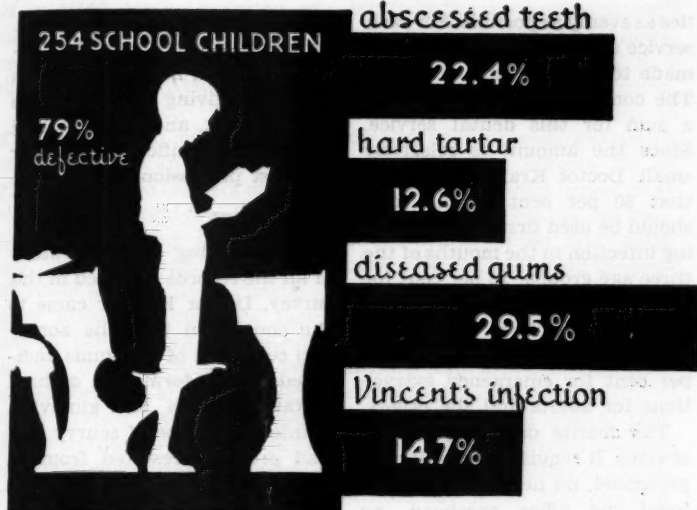
Besides abscessed teeth in the pre-school group on relief, the presence of infection was indicated by the positive reaction of one child to Vincent's angina and two smears that showed the presence of fusiform bacilli.

Children of School Age

Although the number of cavities recorded for the 254 children of school age was average, the challenging aspects of their problem were revealed in the number of abscesses, the presence of hard tartar, diseased gums, and the positive bacteriological findings. Twenty-two and four-tenths per cent of the children had abscessed teeth; 12.6 per cent, hard tartar; 29.5 per cent, diseased gums; and 14.7 per cent, positive Vincent's angina organisms.

Several of the children had 1 to 3 permanent molars decayed to the gums (with one or more abscessed). On being questioned, their parents admitted the children had suffered with toothaches but lack of funds prevented them from seeking relief in a dental office. Only a very small percentage of these school children had ever had any dental attention.

Records of 242 in the adult group showed that only 24 had healthy mouths, and of these 19 were edentulous. Sixty-three had abscessed teeth; 218 had a total of 597 cavities; and 218 showed diseased gums, about 50 per cent of which were capable of correction by prophylaxes and treatments. The teeth of 90 per cent of



the adults over 45 were in such a deplorable condition that extraction was the only remedy possible. In checking over illnesses in this group, Doctor Kramer found that, out of the 174 who reported recent illness, there were 57 cases in which the mouth conditions could be credited as a probable factor.

Everyone of the adults needed a thorough prophylaxis, and a surprising number, 22 per cent, gave positive findings in Vincent's angina; three giving almost pure cultures. Diphtheria germs were found in three mouths. Doctor H. R. Ross, collaborating epidemiologist, United States Public Health Service, and Floyd Brown, bacteriologist in charge of the state laboratory examined the smears and reported the findings.

Only strong cultures were recorded.

Immediately upon completion of the study the local group with Doctor Kramer began to formulate a plan for giving dental service to the families examined. They developed a comprehensive program which is now in operation.

It was based on the idea of directing families on relief to private dental offices rather than to clinics. In Marshall County, which has a population of 20,000, it was not practical to establish a centralized clinic. It was thought wiser to make use of the seventeen well-equipped dental offices now in operation in the County. The dentists agreed to take care of the patients, apportioning the work to be done in various locali-

ties as evenly as possible. For each service a uniform charge is to be made to the poor commissioner. The commissioner has budgeted a sum for this dental service. Since the amount is relatively small, Doctor Kramer suggested that 50 per cent of the fund should be used first for eliminating infection in the mouths of the three age groups; 20 per cent for corrective and preventive work for the pre-school and school children; and the remaining 30 per cent for emergency extractions for adults and the others.

The merits of this plan are obvious. It requires no additional personnel, no new dental equipment, no office overhead, no transportation costs, and the people are treated with the least inconvenience possible in the

towns which they live in or near. Of course, the profits of the dentist are small, but at least he is no longer giving this service as charity work, and he is enabled to do it at specified times under the best professional conditions.

Conclusions

After making a careful study of all the records obtained in this survey, Doctor Kramer came to the conclusion that the abnormal condition of the gums, indicated by the formation of hard tartar, pyorrhea, and gingivitis, pointed to a type of scurvy that had probably resulted from an insufficient amount of fresh fruits, vegetables, and milk in the diet. As a treatment he suggested, particularly for the pre-school and school groups, the



abscessed teeth

26%

diseased gums

90%

Vincent's infection

22%

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elimination of hard tartar deposits, treating of the gums, removal of infected teeth, restoring of cavities, instructions in the correct use of the toothbrush and in the importance of a balanced diet.

In the opinion of Doctor Kramer the high percentage of diseased mouths and those showing persons to be carriers of Vincent's angina and other diseases indicated need for an effective oral health program in all the schools of Kansas. He was particularly concerned over the fact that 22 per cent of the school children in this group had abscessed teeth. In a recent article Doctor Kramer gave this warning against the danger of infection in the oral cavity during childhood:

"According to the findings of the major clinics, 70 per cent of the foci of infection above the base of the neck are found in the oral cavity . . . As certain premature deaths, heart disease, and some types of arthritis are charged to invasion of the blood stream by pathogenic organisms during childhood, abscessed teeth having their roots in the very marrow of the bone certainly are important factors in these conditions."

The problem of the adults Doctor Kramer thinks should be considered separately from that of the children. Infected teeth and abscessed roots should, of course, be removed, and carriers of communicable diseases ought to receive special treatments and instruction in mouth health. Doctor Kramer believes that information

could be distributed to adults regularly in the form of pamphlets from the poor commissioner's office and by means of local newspapers. As to the children, it is largely a problem of education. Every effort should be made to develop an intelligent oral health program in the schools. To do this Doctor Kramer urges that teachers, school boards, dentists, public health nurses, and health officers be enlisted to aid the program in their own localities.

On the need for immediate action toward making citizens dentally conscious Doctor Kramer expresses himself forcibly:

"If there were a disease that attacked the fingernails causing decay, abscesses and loss of health in nine out of ten children and adults in the nation, every medical college, clinic research laboratory and foundation would be busy in their efforts to solve the problem. Nine out of ten children suffer with the endemic disease of their teeth which causes the very things mentioned above . . . Furthermore, pus and germs in the mouth are mixed with every morsel of food the child swallows . . . It is a sad state of affairs that only a few leading minds in the dental and medical professions have recognized this condition as a challenge to our knowledge and to our civilization . . . If the men outside the profession see the dire need of an active, vitalized, fight against these conditions, surely the men in the allied medical professions should awaken to their obligations."

HAVE YOU A PICTURE?

OF a dentist or a dental scene that is newsworthy?

OF an informal, candid view of dentists? (Such as shown on pages 469-477, April, 1937, ORAL HYGIENE.)

OF a dental meeting? (See pages 920-921, July, 1937, and pages 1178-1184, September, 1937, ORAL HYGIENE.)

OF dental sportsmen? (See pages 924-925, July, 1937, ORAL HYGIENE.)

OF any interesting phase of dental life?

If you have, please send the picture or pictures to the Editor, ORAL HYGIENE, 708 Church Street, Evanston, Illinois.

We pay three dollars for each picture suitable for publication.

The QUESTION is—

by W. A. MOLINE, D.M.D.

THAT THE PEOPLE should be educated in problems of dental health is conceded. But the question is, *how shall they be taught?*

To keep people in darkness on questions of public welfare is a practice that belongs to the middle ages. To the ancient feudal system belongs the right of the overlords or government to dictate to their subjects what they shall do and know and what they shall not do and not know.

Strangely enough, in this enlightened day there are nations whose policies and actions reveal a tendency to return to the old feudal system. And, following in the footsteps of national policies, organizations and individuals often think and act retrogressively. Here indeed is a grave danger that dentistry will do well to avoid.

Often retrogression is mistaken for conservatism. These two are diametrically opposed. Conservatism may exhibit caution but the action or movement is always forward. Retrogression denotes motion backwards, a change from better to worse. No dentist except the most stupid or selfish will deny that the people need to be enlightened on dental problems. But the perpetual bickering on method of public education by the dental associations has resulted in not only inactivity but

actual retrogression. We of the dental profession are behind the times!

Every dentist has had the experience of having a four or five year old child in his office with badly broken down teeth and a seriously crippled masticating apparatus, not to mention the infection that this condition has brought on.

The parent is at first regretful and expresses the wish that the best be done for the child, but have you noted the bitterness behind the statement that invariably follows "I wish that I had known—." And who is responsible for the parent not knowing?

The dental profession stands indicted!

The question is now: What is the profession going to do about it? Are we to continue in the present state of apathy? Must we continue to listen to admonitions of educating the patients in the dental office? Must we continue to feed the avid public with an eyedropper of news items and office pamphlets that are never read? Must we continue to feed the public with a stew of semi-truths mixed with a sauce of commercialism?

Evidence shows that dentists everywhere are clutching at a straw. Any type of education for

the public is better than none, they say. Doctor Paul H. Belding of Wausonsa, Iowa, makes the following statement in an article to prove the desire of dentists to participate in an educational program: "Over 32,000 dentists responded favorably to an educational program sponsored by a manufacturer of a non-accepted product. For how much longer can this voice be denied?"

Think of it! Thirty-two thousand dentists want somebody else to pay for advertising their business. That the picture to be presented is tainted with commercialism doesn't matter. But to pay for their story, told in their own way, to their own interest—that is unethical, unprofessional, and smacks of the almighty dollar!

Thirty-two thousand dentists want national publicity for their profession but are content to let others write their copy and pay the bill.

The question is—How can the dentists be made conscious of desirable copy controlled by themselves? How can the American Dental Association be inculcated with a sense of pride which will make it responsible for the financial backing of its own publicity program? How can the demands for more and better dentistry be met? How can the dentist reach all the people?

There is one method that to date has not been tried. It is the only method to produce these desirable results—of answering the foregoing questions.

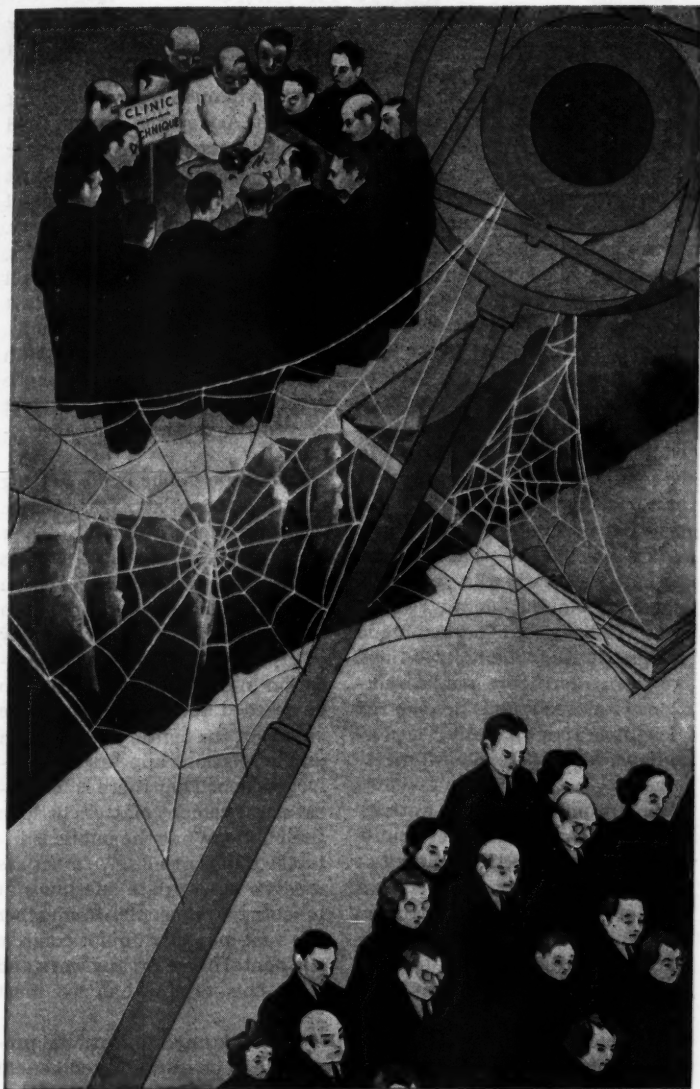
The American dentist through

the American Dental Association must appropriate the driver's seat and must take into his own hands the reins guiding his destiny. He must control his own publicity. He must pay his own publicity bill. He must tell all the people his story through a nationwide program.

The many feeble attempts at publicity previously have resulted in failure for several reasons. First, no national program using concerted effort in all parts of the nation simultaneously has been tried. Local efforts gain little response from the masses. No two local efforts attempt to reach the same goal.

Second, many local programs require that the people come to the dentist: that is, dentists give talks to civic groups, Parent-Teacher Associations and schools, pamphlets for distribution in our offices, and exhibits for the public. But the people will not come to listen to something in which they are not interested. And why are they not interested? Simply because no one has yet appealed to the proper side of human nature on a mass scale concerning dental health.

Third, the American Dental Association will never obtain results so long as they try to get publicity worth dollars for a penny's investment. In this day of big business, rapid transit, and national public relations it costs money to get the things worth while. And certainly harmonious and friendly public relations are worth while.



"Have we been sacrificing public relations for technical procedure and widening the chasm between ourselves and our patients?"

As soon as dentists become reconciled to paying for national publicity; as soon as they are willing to let people know what service they offer, just that soon will there be more and better dentistry.

Dentistry should be proud of the large number of men in its rank who are constantly advocating increased efficiency, improvement in operative procedure, improved technique. The existence of these men of high ideals and honor are an asset to the profession. Their generosity in giving to the profession the results of their efforts in research and study is to be commended. It is an indication of a healthy mental attitude and progress in the profession.

Is it not possible that we have become so absorbed in the technique of "making" dentistry that we have neglected the technique of "distributing" dentistry? Have we been sacrificing public relations for technical procedure? How little about patient relationship we hear at the dental meetings!

One prominent dental authority states that personality counts for 85 per cent in the building of a dental practice. Fifteen per cent of success is due to technical efficiency. Interpreting public relations as the "personality" of dentistry, it would seem that there has been a decided overbalance of "technique" in our dental meetings.

There is a continual cry for "more and better dentistry" and it is justifiable too. But has any-

one ever thought of occasionally changing the cry to "more and better dental patients"?

This will open a new avenue of thought. Aside from an admitted economic asset, more and better dental patients would be the first step in carrying out a successful crusade of preventive dentistry. All the diets, serums, anti-toxins, and techniques of procedure will be of little value if we do not first win the confidence of the public. We must establish contact with the people to be able to render the greatest service when the best preventive methods are discovered.

Truly, the public is *not* getting the story of dentistry fast enough. Children are growing up. Their teeth are decaying. Still parents await someone to tell, yes, even remind them, that their children need dental attention. In this day of rapid action in all things, education in dental health must also be speeded up. To the public, the inertia of the dental profession in public relations appears to be retrogression. That there is technical advancement matters little to the public. What the public is interested in is results. We must use modern up-to-date methods of reaching the people. Remember the vast majority do not come to the dental office for any work and it is this group that we must reach.

A well planned educational program can be of unlimited benefit to the profession. To many dentists, an educational program would no doubt seem an added

expense with perhaps a questionable return value to them. Such an idea could not be further from the truth.

A well planned educational and publicity program will create a friendly attitude of the public toward the profession that no other effort could induce. By giving the public a better understanding of our motives in serving them, we can make them more sympathetic toward us and less likely to agree with ideas of socialized and advertising dentistry.

A well planned educational program will create autonomy and

unification within our organization. It will do so by stimulating pride and a desire to be identified with a progressive group.

A well planned publicity program will bring to the public a desire for more and better dentistry.

A well planned educational and publicity program will bring more and better dental patients to your office.

Now—the question is—*When* will *you*, the dentists of America, act?

210 Rookery Building

Spokane, Washington.

DENTAL MEETING DATES

American Society for the Advancement of General Anesthesia in Dentistry, Belmont Plaza Hotel, New York City, Monday, October 25, at 8:30 P. M. Dinner at 7 P. M.

Ohio State Dental Society, seventy-second annual meeting, Mezzanine Floor of the Neil House, Columbus, November 8-10.

Greater New York Dental Meeting, thirteenth annual meeting, Hotel Pennsylvania, New York City, December 6-10.

What Is a DENTAL HYGIENIST?

by MARGARET JEFFREYS, R.D.H.*

TWENTY-TWO YEARS ago the profession of the dental hygienist was established. The ensuing years have been marked by surprising progress and constructive development in this profession.

Created for the purpose of performing actual prophylaxes as the first step in preventive dentistry and to assist in the education of the public in mouth hygiene, the dental hygienist has found four different fields for service: Giving instruction and prophylactic service in the public schools throughout the United States; reducing the possibility of postoperative infection in hospitals and institutions; prophylactic and educational service in industry; and assisting the dentist in private practice by giving prophylaxes and instructing dental patients.

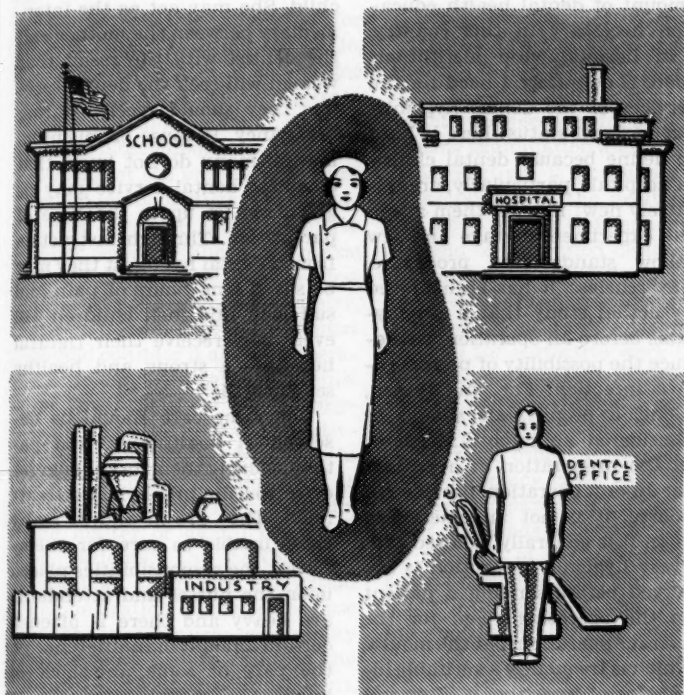
As to the attitude of the federal government toward them, I quote from the school health program publication of the White House Conference, "Dental hygienists—their contributions are especially valuable in the field of education and their professional service offers a means for health instruc-

tion unexcelled by any other form since it gives opportunity at each sitting for a good health lesson; the repetition of which is just as necessary as the repetition of a lesson in English or Mathematics." This is, no doubt, the real reason why the dental hygienist has found public school work her greatest field of service. Her approach to the child in the classroom is different from that of other teachers and thus she obtains more significant results.

She wears a uniform that has a direct appeal to the child. She is an "outsider." Her story is something new. By her simple and frequently unique method of presenting her subject, she arouses curiosity and the desire for more information. Each child, during an examination or while having his teeth cleaned, is treated as an individual. His pride is stimulated and he is encouraged by a little praise to follow the instructions given him. Because the dental hygienist has ability to handle children, she frequently can inspire confidence and trust during the first visit to the dental room and thus eliminate the traditional fear of the dentist.

It is generally believed that

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... the dental hygienist has found four different fields of service.

more children are going to the dentist now than at any other time in the history of the dental profession; that more adults are receiving dental health education through the medium of the child in school and directly through the Parent-Teacher organizations and Mothers' clubs. Successful as this work has been, it is to be regretted that the dental profession has not yet gained sufficient recognition to have its service placed on the same level as general

medicine, so that it might obtain, from the state and federal governments, money for dental health education in proportion to what is being expended for medical care. This would make possible the employment of more dental hygienists for public health service. If we accept the figures that state there are but 20 per cent of the people going to the dentist now and less than 25 per cent using a toothbrush, it may be readily seen that there is a vast

amount of dental health education necessary in this country.

In hospitals and institutions there is definitely a need for the services of the dental hygienist but her real status there is hard to define because dental clinics, in hospitals, particularly, are relatively new; most of them are in the experimental stage and few follow standardized procedure. Nevertheless, it has been proved by actual study that a prophylaxis before an operation will reduce the possibility of postoperative infection. For this reason, alone, a prophylaxis should be considered an important factor in the preparation of a patient for an oral operation, provided of course, it is not an emergency case. It is generally believed that every hygienic precaution is observed before sending a patient to the operating room for the average operation, but the mouth, which is frequently a veritable incubator of infection, is often neglected.

True prevention, members of the dental profession all over the world agree, should begin with the expectant mother. Efforts on the part of our public health nurses are rapidly bringing hundreds of such mothers to our hospitals for prenatal and postnatal care. This procedure opens another avenue of approach for dental health education through the dental hygienist employed by the hospital. She is in an enviable position to disseminate such information as will be valuable not only to the mother but to the

child. She may act as the intermediary between the mother and the dentist with the result that women will seek the dental services they should receive during pregnancy. Because of misinformation many do not know that complete dental service may be given almost up to the time of parturition. Through instruction from a dental hygienist they may be saved long hours of pain and suffering, and their children will eventually receive their rightful heritage—a strong and healthy set of teeth.

The same care should be observed in institutions, and patients during their stay should receive routine prophylactic treatment. They are ill and in many cases unable to care for themselves; the responsibilities placed upon the nurses and attendants are heavy and there is often a certain amount of indifference on the part of some and lack of knowledge of the necessity of mouth hygiene on the part of others. The dental hygienist is able to adapt herself to such a situation and relieve the dental interne or resident dentist who usually has more work than it is possible for any one person to do.

Industrial Clinics

Of the work of the dental hygienist in industrial clinics, little more can be said about her duties than has been mentioned in the foregoing paragraphs. Her chief responsibility is the prophylactic work of employees recommended to her care and the educational

program that is conducted for each patient entering the clinic.

The fourth field of service for the dental hygienist is the private office and, in my opinion, it is one of the most important, primarily because of the prophylactic work which many dentists believe consumes time they might devote to other services. Since prophylaxis is considered one of the first measures of preventive dentistry, it would seem that every dentist should consider it almost imperative to employ a dental hygienist for this task alone. But prophylaxis is not the limit of the activities of any dental hygienist in a private office, if she is alert to her opportunities. There is, again, the matter of dental education of patients: the teeth, their functions, their care, the actual demonstration of the correct use of the toothbrush, and many other facts so important to the health and welfare of any patient.

YOUR COMMENTS PLEASE!

Controversy swirls about the subject of the dental hygienist. Some states have them; others do not. Some dentists say, "I couldn't practice without them;" others say, "I can't get along with them." There are arguments for and against the dental hygienist. We should like to receive and publish more of both kinds of comments. Your letters on the subject will be welcomed by the Editor.

As a practice builder, the dental hygienist has unlimited opportunities. While giving a prophylaxis, she may impress upon her patient the necessity for a regular routine examination and prophylaxis. Further, it is much more in keeping with the prestige of the office for her to telephone at the end of the period designated by the dentist and following the completion of the patient's treatment make future appointments for him for corrective work that the dentist should do. So often a dentist working without a dental hygienist will find his time so filled with other appointments and emergency cases that he is obliged to delay calling a patient. That only leads to dissatisfaction on the part of the patient who, after a period of time, will decide that the dentist is not sufficiently interested in his personal welfare.

Additional Duties

There are still other duties in addition to the ones just mentioned that the dental hygienist may take over, such as assisting at the chair when the dentist is doing the deeper scaling required by some patients. She may take care of books, roentgenograms, and other tasks between patients; thereby relieving the dentist and his assistant of many arduous but important duties. In fact, the dental hygienist should be quite willing to undertake any task, regardless of how minor, that will add to the smooth and efficient operation of the office.

The trend in dental health

education at the present time is an upward one, and it would seem that the dental hygienist should prove an excellent aid to the dentist in all that he is trying to accomplish. The fact that she is a woman of training, with an education adequate for her vocation, and has a desire to be of service will contribute to her success.

It is true, that to attain her objectives, the opportunity to do her best in her chosen field, the privilege of recognition by other professions, the cooperation of

the dentist in the work that she is attempting to do, her education should be better, and more uniform regulatory laws should be adopted by all the states. There is probably not one dental hygienist who feels that her background of education is sufficient to cope with all of the situations she may meet in the day's work, and it is this decision that has led them, in all parts of the country, to enroll in classes for the purpose of increasing their knowledge of the type of work they are doing.

DENTAL HYGIENISTS IN HOSPITALS

In the report of the Annual Census of Hospitals published in the *Journal of the American Medical Association*¹ there are some figures that should be of significance to everyone interested in the future of the dental hygienist. Apparently there is a vast part of the field in hospital service unexplored and undeveloped by dental hygienists.

Out of 6,189 registered hospitals in the United States only 394 employ dental hygienists; the number of young women in this service being 484. A total of 8,646,885 patients were admitted to these hospitals during 1936.

The seven states employing the largest number of dental hygienists are:

	Hospitals	Dental Hygienists
New York	89.....	108
Pennsylvania	54.....	70
Massachusetts	32.....	37
California	23.....	33
Illinois	17.....	19
Michigan	15.....	18
Texas	13.....	14

¹Council on Medical Education and Hospitals of the American Medical Association: Hospital Service in the United States, J. A. M. A. 108:1035 (March 27, 1937).

The dental hygienist should feel rather proud of the fact that she began with a little more in the way of educational requirements than some of the other professions. Standards in many of the schools have been raised until now, Hawaii demands four years of training; four other training schools have raised their course to two years; and the two schools in Pennsylvania, in addition to the one year course, have another which enables applicants to complete the first three years in the Teachers' College and major the fourth year in Dental Hygiene.

Speaking of our profession, I am certain that all of our members would heartily endorse a standardization of training school courses, subject to such needs as are erected by standardized state law. Unfortunately, we are not in a position to do other than express ourselves, and must await the decision and the action of the dental profession. May it not be long until they, too, realize our needs and assist us in attaining our objectives!

*State Board of Health
Dover, Delaware*

NOTICE

WRITTEN EXAMINATION for appointment as resident dental interne at Lincoln Hospital, Dept. of Hospitals, City of New York, will be held during Christmas week of this year, for appointments to be made for the period from July 1, 1938 to July 1, 1939.

Internship offers a thorough practical training in anesthesia, exodontia, and oral surgery. Two internships are available.

Applications should be made to M. Hillel Feldman, D.D.S., 730 Fifth Avenue, New York City.



MICHIGAN EXAMINES

FOR THE last two years a Committee appointed by the Michigan State Dental Society has been making an intensive study of the status of the dental hygienist. Their report, which was published¹ this year, is a significant, interesting, and unbiased one because of the method used. In an effort to bring conflicting points of view into focus, the Committee during its sessions interviewed educators, dental examiners, periodontists, hygienists, and many members of the dental profession.

Under *adverse comment*, the main points of view brought up for discussion before the Committee were:

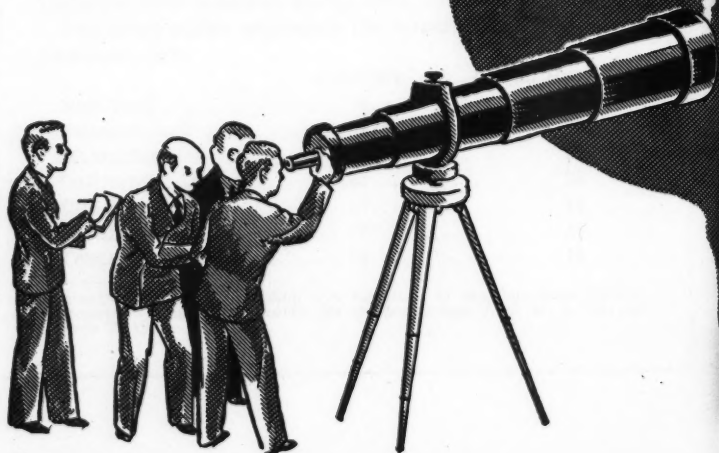
1. The training of the dental hygienist is inadequate.
2. The work of cleaning, filling, and scraping teeth, as well as gum stimulation, is too important

¹Report of the Committee on the Status of the Dental Hygienist, J. Mich. State D. Soc. 19:108 (May) 1937.

to be delegated to anyone but a dentist.

3. The public has been encouraged to use the services of dental hygienists, especially in hospitals and in group practice, until many patients now erroneously believe that they can dispense with all prophylactic service by dentists.

4. Because the hygienist has

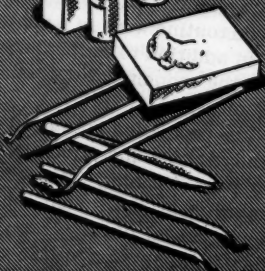
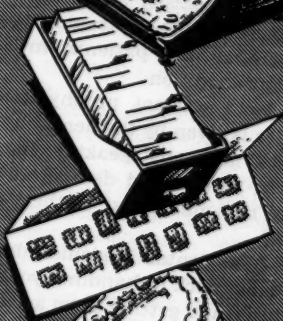


DENTAL HYGIENIST

"Public Health
Dental Hygienist"



"Registered
Dental Nurse"



been trained to consider herself a specialist in her particular field, she has developed an unwarranted feeling of superiority.

5. The field of the hygienist lends itself to the exploitation of the public by unscrupulous dentists.

The *favorable comment* from those who are in sympathy with the objectives of the dental hygienist brought out these points:

1. The dental hygienist is an economic necessity as an aid to the busy dentist in keeping the mouths of his patients in a healthy condition.

2. More efficient prophylactic service is given by the dental hygienist, generally speaking, than by the preoccupied dentist, at a more reasonable cost to the patient.

3. The dental hygienist does valuable work in handling young children and getting them accustomed to dental treatments.

4. A properly trained hygienist exerts a beneficial influence on a dentist stimulating him toward greater progress.

5. A hygienist trained and willing to do routine work in a dental office, in addition to prophylaxes, aids in the economical operation of the office.

6. The profession is in need of a high type of young women with a broader training somewhat commensurate with that of a trained medical nurse.

The Michigan Committee approached these conflicting points of view with the purpose of finding out if the hygienist was a

menace to the profession because of law violation, and if, for that reason, her training should be discontinued.

In the matter of law violation, the Committee found a relatively small number of instances in which hygienists had deliberately tried to practice independently, taken patients with them when transferring from one practice to another, or deliberately overstepped the licensed activity of the hygienist in removing deposits below the gum line. The Committee was of the opinion that the law violation in the mechanical process of cleaning the teeth by the hygienist is largely the result of the ambiguity of the law which sets arbitrary limits for this operation.

Objections to the hygienist on the grounds that she has assumed a position of undue importance, the Committee found, were based largely on a mild resentment throughout the profession over an attempt to place a group of young women with limited training on a level and in competition with the profession itself in cleaning teeth. It was suggested that this objection might be overcome by eliminating the term "hygienist."

The Committee was unwilling to concur in the opinion that the cleaning of the teeth, done without serious involvement of supporting tissues, could not be delegated to anyone with less training than a dentist. But it agreed with those opposing the hygienist that the idea lent itself to exploita-

tion by unscrupulous dentists and traced this result back to an erroneous impression given the hygienist in the schools. Because she has been encouraged by instructors to think that her objective was full time prophylactic service, she has overemphasized this part of her work. If the hygienist works on a commission or the security of her position depends on the number of prophylaxes she performs in a day, the Committee believe that exploitation is almost inevitable.

After analyzing the arguments for and against the dental hygienist, the Committee came to the conclusion that "inasmuch as the hygienist is already established as a reality, with a number of dental schools engaged in her training, and many members of the profession keenly alert to her possibilities . . . the evidence offered against her as valid reasons for her discontinuance can hardly be considered, at least at this time, as justifiable reason for abolishing at one stroke, all the accrued and potential good of which she is capable."¹

The Michigan Committee, of which the chairman was M. Webster Prince, D. D. S., offered the following recommendations to improve the status of the dental hygienist in relation to the dental profession:

1. That the present course of instruction in this state in dental hygiene be changed.

2. That the course be made elective. One course to be given in public health work. The other in dental office assisting.

3. That the use of the term "Hygienist" be applied only to the course in public health work, such as "Public Health Dental Hygienist."

4. That the course in dental assisting be given the term "Registered Dental Nurse."

5. That the time required for both these courses be two years.

6. That the entrance requirements for the course in public health work be a teacher's certificate or equivalent.

7. That the entrance requirements for a "Registered Dental Nurse," be a high school certificate, and credit from a recognized source in office management, bookkeeping, and typing. (Such a course can, if desirable, be worked out with accredited Business Institutes based on ten months work.)

8. That the college course in dental nursing include laboratory technique in making models, carving and casting inlays, preparing impression materials for insertion, mixing cements and alloys, developing and mounting radiographs, care of instruments, sterilization; some knowledge of the action of drugs and medicines most commonly used in a dental office, general and local anesthetics, emergency measures in case of pain or shock, and a thorough training in the removal of calculus, and the polishing of the teeth.

9. That our present law governing the licensing of hygienists be changed to conform to the above changes, as well as the part of the law which prohibits removal of calcareous deposits below the gum line.

10. That the law, when written, provide for the licensing of dental nurses trained to clean, scale, and polish the exposed surfaces of the teeth, and those immediately under the free margin of the gum.

11. That a committee be appointed to work out the details of these proposed changes, in collaboration with the dental faculty of the school, and the State Board of Dental Examiners.

THE BUM'S RUSH

by FRANK A. DUNN, D.D.S.

HE STOOD IN THE doorway between the reception and operating rooms and introduced himself to Doctor Norman who was working at the chair. Distinctly he gave his title of "Doctor" and his name. Doctor Norman said he was busy. The caller merely wanted a minute or two, and there was an air about him that suggested he should be given the time. Doctor Norman repeated that he was busy and continued with his work. The man left without telling what his thoughts were, but they probably could be surmised, and just as probably they wouldn't look well in print.

Half an hour later the man's face and name began to shape themselves in Doctor Norman's mind. He had seen that face a dozen times and had read that name scores of times in dental literature. Who was he? Finally he had him placed. He was one of the most distinguished members of the dental profession, known wherever dentistry is practiced. His voice had frequently been heard over the air in near-national hookups, and from the platform of many dental conventions. And Doctor Norman couldn't have given less consideration to a wayfarer asking for a dime.

But distinguished or undistinguished, that man was one of Doctor Norman's profession, one of his own kind and clan. He had in a gentlemanly manner introduced himself and, in a rather ungentlemanly manner, had been given the bum's rush.

It is only fair to say that it was a slip on Doctor Norman's part, and a lesson to him, because he is anything but ungentlemanly. He undoubtedly felt as hurt as his distinguished colleague.

Are We Head Waiters and Bus Boys?

A physician who was an old friend of mine dropped into my office. Fire was in his eye and smoke on his tongue.

"You dentists don't know how funny you are," he said. "You're just a laugh and a great big laugh at that. You're like a lot of head waiters."

"All of us?"

"No . . . there are exceptions . . . some of you are like bus boys. I've just come from a dentist's office . . . consulting with him about an x-ray of a case he referred to me. First, I tried to telephone him but he was busy. An hour later when I called on him his secretary said he was busy, but he would see me in a minute.



"But he kept on reading and I kept on typing."

He kept me waiting in his reception room for fifteen minutes. I wanted to tell him a thing or two, but there was a ten dollar bill in the case, and the way things have been a man would almost stay under water fifteen minutes for that money. It isn't right."

"Maybe he couldn't get away from the patient."

"No. I've had that sort of treatment a number of times. A physician would give a dentist or another physician an immediate audience. If he gave the kind of a reception that I have had from dentists it would certainly be the exception. In fact it would be unthinkable . . . and it ought to be unthinkable with you fellows."

Getting that and a bit more off his chest, he went whistling on his way. He had exaggerated, of course, but he had spoken much truth.

Why should the reception given him be an exception among physicians and quite common among dentists? Why unthinkable among physicians and not among dentists?

Many dentists might say, "I have a rule that the patient receives my undivided attention."

It would be more truthful if he said, "I have a rule that the dollar receives my undivided attention."

That type of man wants to make every minute count. He values each hour by the money he gets out of it. Are you old enough to know intimately (as intimately as one can know them) men of this type who have been

in the profession 30 to 40 years? Buzz them and they will frankly tell you they have been saps. They really don't have to tell you . . . one look and you know without being told.

Maybe We are Bell Hops

But the dollar is not always the reason for this unfortunate condition, nor is it ignorance or ill-manners. At times it may be a callous growth that was harmless and cartilaginous in the beginning, and, unnoticed by the dentist, developed into something sinister and horny.

At other times it may be a camouflage that hides an inferiority complex, a sort of silk hat and tails on a bell hop. This last blast is not mud-slinging criticism. It is simply a verbal wallop at those camouflaged bell hops, for the delight of myself and of hundreds of dentists who are thoroughly fine fellows and who would like nothing better than to deliver the wallop in person. A CALL FOR MR. SNOOTY,¹ one of the articles I have contributed to ORAL HYGIENE, was a first-cousin to this Bum's Rush, and in it I delivered some bruising punches. Evidently it said what many dentists all over the country would have liked to say because it brought in more letters of applause than any other article of mine.

I entered the office of a dentist known to me by some of his writings. Naturally I anticipated a

¹Dunn, F. A.: A Call for Mr. Snooty. ORAL HYGIENE 25:796 (June) 1936.

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fairly pleasant reception. I gave him my title and name. I had no chance to give him more. He blurbed, "I can't see you now . . . if you want to see me you'll have to come some other time." And he vanished into an inner room. A few doors away I dropped in on a dentist I knew slightly. I told him what I thought of the man I had just called on and asked his opinion of him. He answered, "He's a punk with a yen for advertising . . . he has boys passing bills around the neighborhood. He would give you the sort of reception he did, but he's the type you wouldn't kick out of your way."

Maybe that paragraph has personal animus in it, but some readers may enjoy it because they have had similar experiences and would like to say the same thing.

A Modified Bum's Rush

I was sitting at my desk typing a manuscript when a dentist who is a friend of mine and a good scout entered. He said he had written a brief talk he was to give at a luncheon, and that he would like to read it to me for any suggestions I would care to make.

"Go ahead . . . I'll be glad to give you any help I can."

He began to read. I began to pick at the typewriter. Every minute or so I would stop typing, look at him, and maybe speak a word. Within three or four minutes there was a half-snarl in his voice. But he kept on reading and I kept on typing. At the end of seven or eight minutes, before he

had reached the end of his talk, he suddenly rose and rasped, "Well, I'll be getting along."

There was an angry gleam in his eyes and a hurt expression on his face as he started for the door.

I said, "Bill, just a minute . . . come back and sit down. I want to tell you something." He was set on going and I had to coax him to return.

"You thought I was discourteous, that I was a heel, didn't you?"

He was almost too sore and sour to talk. "Well, if you want the truth, that isn't the half of it. I thought you were a lousy heel. I needed a lift and believed you would be gentleman enough to give it to me. You acted as if I were some scrub trying to borrow money. I had a right to a courteous reception."

"Sure, Bill. So far you're right. But let's go a bit further. I did act like a heel and I hated to do it, but I did it on purpose."

"You did it on purpose. Why?"

"Two weeks ago I dropped in on you. You were meticulously setting up teeth in your laboratory. I had something important I wanted your opinion on. I told you so and you said, 'Go ahead.'"

"I went ahead, explaining to you what was on my mind. And you went ahead meticulously setting up your teeth, stoning them here and there and articulating them. You may recall that I cut the interview short. You just naturally did the same ill-mannered thing to me that I had to force

myself to do to you. And you almost frothed at the mouth with anger when I did it. Now you have the floor . . . go ahead and answer that."

A big grin spread over his face. "Well, I'll be darned! I never thought of it in that way, but you're certainly right. I was playing the part of a heel when you dropped in on me and I didn't know it. Thanks for the tip."

"Come on, let's go over that luncheon talk."

That's just another form of bum's rush you'll get from many dentists. But it's different when the shoe pinches your own foot. If it's a weakness of yours, just imagine yourself trying to explain the superiority of a gold partial over a vulcanite to a patient who is trying to work out a cross-word puzzle.

"Has it occurred to you," asked a dentist who had read most of this manuscript, "that there may be a personal side to this bum's rush business? Some of your writing may have caused unfriendly feelings. I remember one article of yours in which you ridiculed the manners and education of a dentist. You described him as a sort of hill-billy who blew at his coffee or fanned it with his hat to cool it, and things like that. You certainly made him out to be a sap. That probably made some fellows sore."

"I remember the article . . . it was OWLS OR CUCKOOS.² If anyone had a right to get sore about what

was said in that piece of writing, I was the one. The word picture poking fun at the manners and bearing of a young dentist was a description of myself. The whole article was autobiography and the picture could have been a lot funnier . . . I held out.

"No, there's hardly anything to that unfriendly feeling angle. An endless number of dentists have invented dental instruments and gadgets; another endless number have entered the specialist field, exodontia, for instance. These new endeavors led them into calls upon other dentists. Ask some of these men about their experiences. You may be shocked by their profanity. They'll use stronger words than *head waiter*, *bus boy*, and *bell hop*."

Cultural Courses Needed

Doctor L. M. S. Miner, former president of the American Dental Association, has declared that cultural courses rather than practical courses in the dental curriculum is the great need of the profession. He has said that, in technical and remedial activities, dentistry takes front rank in the United States, but from the intellectual point of view its position is far from secure or satisfactory.

Lack of cultural courses may have something to do with the uncultured bum's rush. Because of such a lack many of us may develop a pseudo-superiority complex. Size up a type of senior dental student. There he is, one day, a young man who might be

²Dunn, F. A.: Owls and Cuckoos, ORAL HYGIENE 24:989 (July) 1934.

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working his way through college, and more power to him for doing it. Perhaps he waits on table for his meals in a restaurant where dishwashers, cooks and musical soup-eaters can bawl him out without a comeback. Perhaps he is a part-time paper hanger and painter in homes where housewives and servants can order him around. The next day, he is a full-fledged professional man addressed as "Doctor," with an office all his own, a telephone, and maybe a streamlined secretary to answer his beck and call, with no one having the right to tell him when or where to get off. Few men in commercial life climb to those heights, and when they do it takes them 30 or 40 years. He steps up to them in one day. Naturally it would go to almost anybody's head. But it's sad that it stays there permanently with so many.

Dentistry is a kind, generous, and a great profession. It has opened highways to many of us who might otherwise have been shuffling along byways; it has given us opportunities to get the worthwhile things of life as well as to give them to others.

But Doctor George B. Winter, said in an address, "Dentists have improved in knowledge, skill and culture, yet so halting has been their progress that an official American Dental Association committee was obliged to report, 'Public esteem for the profession of dentistry is not so high as that for other professions.' "

In other words, maybe the public is giving the profession the same sort of bum's rush that many dentists have been giving one another.

9107 Wade Park Avenue
Cleveland, Ohio

Editorial Comment

GIVE ME THE LIBERTY TO KNOW, TO UTTER, AND TO
ARGUE FREELY ACCORDING TO MY CONSCIENCE

ABOVE ALL LIBERTIES. *John Milton*

ARE WE READY FOR UNIONISM?

A LITTLE MORE than 100 years has seen the emergence of trade unionism from groups of secret, illegal bodies to vast organizations protected and sponsored by federal legislation. In the beginning, combinations of working people were considered conspiracies in restraint of trade and, therefore, contrary to public policy. Twenty-five years ago it would have been fantastic to suggest that dentists, dental laboratory workers, dental supply house employees might organize into unions. Today such suggestions are being made; they do not carry the mark of the fantastic, but are being given serious, and frequently enthusiastic consideration by dentists as well as those in the dental industry.

With the current wave of unionism, which historically portends "good times," it is not unusual that attempts should be made to organize the dental industry, particularly laboratory workers. Such attempts have been made before and have been aborted by the vigorous action of laboratory owners. Now employers can no longer take direct action when efforts are made to organize employees. The Wagner Labor Relations Act prohibits interference on the part of employers with the right of employees to organize and to choose associates to represent them in collective bargaining. Regardless of what the employer likes, or for that matter what the employee prefers, if 50 per cent of workers in a plant, shop, or laboratory can be organized, the union that accomplishes such organization can act as the sole bargaining agent for all the employees under "majority rule."

Liberal-minded people agree that trade unionism is a necessary instrument for maintaining and improving labor standards. There is nothing wrong with the principle of collective bargaining or of employee protest by strike. Seizure and destruction of property, violence, the interference with the free flow of trade are, however, anti-social acts. They should be considered illegal as has been done in

Great Britain under the Trade Disputes Act of 1927, which provides that employers can recover damages from union funds for loss sustained in illegal strikes.

If laboratory workers are organized, the cost of laboratory service will be increased to the dentist, who in turn will presumably pass the increase along to the patient. Thus the cost of dentistry to the patient will be raised. Any increase in the cost of dental care will cause excitement among the social planners and the professional mourners for the down-trodden. Once again they will wall that rapacious private practice must be controlled or abolished and that state control of the distribution of health care is a necessity.

The weight of rising prices falls heaviest on the people who are supposed to profit most under unionism—the working man and his family. His dollar wage may increase but his real wage decreases. He may handle more money, but the money buys fewer goods and services. A few thousand workers in dental laboratories may profit under unionism but hundreds of thousands of other workers will feel the pinch in their pocketbooks when they purchase dental care.

Already working men are beginning to see that economics is a whirl of interrelated wheels and that you can't have more dollars in your pay envelope without more dollars being tacked on to the butcher's and the grocer's bill. The disillusionment comes when the dollars on the bills payable add up to be more than the dollars in the pay envelope.

After laboratory workers are unionized labor organizers will not be satisfied until unionization of the entire dental field is accomplished—supply house employees, dental assistants, secretaries. Finally, the dentist himself will be so buffeted and ravished by increasing production costs that he will be receptive to overtures from labor organizers. He will be promised a minimum wage, maximum hours, a fee schedule, control of competitors. He will sign up, pay his dues, get his "card."

That day the profession of dentistry dies!

Edward J. Ryan

DEAR ORAL HYGIENE:

"I do not agree with anything you say,
but I will fight to the death for your right
to say it."—VOLTAIRE

Georgia Health Education

YOU WILL BE interested in hearing the comments and inquiries that have come to me following the appearance of the May issue of ORAL HYGIENE in which I told of dental health education activities in Atlanta and Georgia.¹

Beginning at home, the Georgia Dental Association appreciated the fact that the program which they are sponsoring and in which Georgia dentists participate was given recognition in ORAL HYGIENE. At the Georgia State meeting many dentists reported with pride that they had read the article and believed that it gave a true picture of work in Georgia. The President of the Georgia Congress of Parent-Teachers sent the article to the national office and also to the Editor of the Georgia Parent-Teacher Magazine. The State School Superintendent and his staff reviewed the article with interest.

Mr. Cator Woolford, whose picture appeared in connection with the Atlanta program, was in Massachusetts and reported that a dentist had recognized his picture and brought the magazine to him.

Letters which I have received from Wisconsin, Pennsylvania, Iowa, California, Alabama, New Jersey, South Carolina, and Tennessee indicate the unusual interest of dentists in the promotion of sound dental education programs in the interests of health and also in the interests of the dental profession. The feature which seems to attract most is that we have not established clinics, that we are educating children and, therefore, adults to seek dental service from the private practitioner in his office. Quoting one letter—

"Your article in the May issue of ORAL HYGIENE is excellent. I wish to especially compliment you on your view on the importance of making children 'dental office minded rather than dental clinic minded.' The only possible way to do this is by not establishing clinics."

To receive such a statement from a member of a State Board of Health is indeed startling, at least in this section of the country it would be considered *heroic*.

"In L——the private practice of dentistry is at a standstill, and 9 out of 10 dentists within our city face ruin of their career in dentistry unless some action is taken to avoid the deadly sting and spread of the 'clinic philosophy.'"

¹Williams, J. G.: Atlanta Acts to Promote Child Health, ORAL HYGIENE 27:608 (May) 1937.

"Thank you for your hard work and enthusiasm in behalf of *private practice*, and the publication of your very fine article, I hope that we may have many more of them in the near future."

At the recent American Dental Association meeting in Atlantic City, many dentists engaged in public health dentistry as well as private practice expressed an interest in the program which has been developed in Georgia. Two definite results can be attributed to the Georgia Dental Health Education program:

1. Dentists have become interested in the public health program of Georgia and feel that active participation is their professional obligation and privilege.

2. The public is beginning to have a conception of dentistry as a health service.

The latest report of the dental survey of school children for the school year 1936-1937 was completed and given to the Georgia Dental Association in May. This report² which has been reviewed in ORAL HYGIENE denotes progress.—J. G. WILLIAMS, D.D.S., *Dental Consultant, Georgia Department of Public Health, Atlanta, Georgia.*

Dichotomy Again

With reference to Doctor S. J. Levy's¹ article, *THE FINE ART OF DICHOTOMY* in the July issue of ORAL HYGIENE, I believe that those directly concerned, the oral surgeons, should have some say.

I have specialized in oral surgery for the last twelve years and my personal association with other specialists of Washington, Oregon, and California and recent consultations with a number of the younger and older members of the dental profession, including the most ethical as well as some large advertisers, have established the fact that this new science of dichotomy (fee-splitting) is not practiced on the Pacific Coast.

Doctor Levy and his immediate circle may be able to tell us something of a parasitic, ignoble and unscrupulous nature, but the dentists of the Pacific Coast, as a whole, can also tell the New Yorkers something about ethics and this, if they have forgotten its meaning, embraces the science of the principles of human morality. It means honesty, decency, and the consciousness of having done your best for your patient and your fellow practitioner, and this without dichotomy.—ERNEST FOWLER, D.D.S., 428 Thirteenth Street, Oakland, California.

²Dental Health Survey Made in Georgia. ORAL HYGIENE 27:1061 (August) 1937.

¹Levy, S. J.: The Fine Art of Dichotomy. ORAL HYGIENE 27:907 (July) 1937.

Ask ORAL HYGIENE

Please communicate directly with the Department Editors, V. CLYDE SMEDLEY, D.D.S., and GEORGE R. WARNER, M.D., D.D.S., 1206 Republic Building, Denver, Colorado, enclosing postage for a personal reply. Material of general interest will be published each month.

Pains in Teeth

Q.—I have a patient, a young married woman, 28. She has a condition that is causing me some concern.

Her teeth are extremely sensitive at the gingival to thermal changes, sweets, and to the explorer. There is no evidence of caries or erosion, but she has four small gingival restorations, a gold foil in each of the upper cuspids, and a gold inlay in each of the lower first bicuspid. The teeth with the restorations are neither more nor less sensitive than the others. The pain originates at cuspid and bicuspid areas of both the mandible and maxilla and travels backward and terminates in her ears. At times it is almost unbearable. It is a sharp, shooting pain. This condition develops about every two or three months and lasts several days and then gradually disappears, although the teeth still remain somewhat sensitive. She first noticed this condition in 1931 during her first and only pregnancy.

I have gone so far as to remove some of the restorations and seal the cavities with cement and zinc oxide and eugenol but this does not seem to help. All her dental restorations are gold. Roentgenograms do not disclose anything, alkaline mouth washes do not help, zinc chloride and phenol have been used as obtundents with no effect. The gingival tissues appear normal and healthy. There is a slight recession of gums both on

the lingual and buccal of the molars and bicuspid.

Do you think that some systemic disorder can be the cause of this condition? I should greatly appreciate your advice on this case.—J. J. D., Utah.

A.—Let me first compliment you on the clear and complete presentation of the case in your letter. It seems to me that this case is probably one of systemic and local origin. I would suspect a dietetic imbalance. There is probably a deficiency in mineral intake and in vitamins B, C, and D, perhaps more particularly in B. There may be, also, an endocrine dyscrasia. I deduce this from the fact of the hypersensitiveness starting during the woman's first pregnancy, at which time the endocrine system is highly activated. Locally, I would suspect traumogenic occlusion, but from your description probably no lack of home care.

Now as to treatment: because of the suspicion of systemic involvement, it would be wise to have a complete physical examination, including blood chemistry. Because these anterior teeth are so likely to become sensitive at the cervical margins from traumogenic occlusion, it would be wise to look into this

phase of the condition first. Then for relief of the local sensitiveness, it probably would be helpful to use formalin in accord with the plan of Doctor Grossman.¹ This treatment has been most successful in our hands.—GEORGE R. WARNER.

Root Canal Fillings

Q.—I should appreciate having your opinion on the following question:

Do you believe in immediate root canal filling after pulp removal? If not, what medical dressing do you recommend for open root canals? About how many days should this dressing be left in?

I removed the pulp by pressure anesthesia using procaine. In my experience I seem to get as many sore teeth by immediate filling as I do by waiting a few days before filling the root canal.

Do you believe that root fillings should ever extend beyond the apex of the tooth? I have always contended that this should not be permitted.

I do not remember of ever having lost a tooth following my present method, but have too many extremely sore teeth after removal of the pulp. This soreness usually lasts from four days to a week, or longer.—R. H. H., New York.

A.—We do not ordinarily fill a root canal immediately after removing the pulp. There is likely to be apical hemorrhage, and it is so difficult to determine if the oozing has stopped, we believe a good root canal filling cannot be made. We would dress such a canal with a mild dressing such as one of the essential oils, and we'd be careful not to have an ex-

cess that would be forced through a root apex.

We usually leave such a dressing in two or three days, and if there has been no soreness in the meantime, and if we feel that there is no "weeping" from the apex of the root, in other words if we find that we can make the canal perfectly dry, we then fill it.

We have abandoned the use of pressure anesthesia in these cases, because of the danger of setting up an irritation at the apex of the root. With our present porcaine nerve blocking technique, it seems to be more satisfactory to remove the pulp under the nerve block. We avoid by all means forcing the fillings through the apex of the root. We do all root canal work under an absolutely sterile technique. And since adopting the sterile technique, we have had almost no trouble with soreness of teeth.—GEORGE R. WARNER.

Saliva Under Denture

Q.—I have a patient who complained of saliva accumulating under his denture. I checked and rechecked for leaks around the denture and could not detect any. The denture had good retention but would eventually drop after this accumulation of saliva.

I have cut the roof out of the denture and made the proper preparation for a roofless denture. This had good retention but is now finally loosened by the same trouble. In the rugae there is a deep crevice into which I can run a probe for some distance, but I have been unable to determine if there is an opening into the nasal cavity. This is the area in which the saliva seems to accumulate, and I wonder if it might be possible that this could be coming through the palate.—P. B. S., Kentucky.

¹Grossman, L. I.: A Systematic Method for the Treatment of Hypersensitive Dentin. J.A.D.A. 22:592 (April) 1935.

A.—I do not believe this saliva could be coming through the palate. It is more likely, I think, that it enters above the buccal flange from an abnormally high parotid gland in the cheek.—V. C. SMEDLEY.

Leukoplakia

Q.—I have a patient, a man, about 55, who wears a full upper denture. Adjacent to the molar teeth, he has an encrusted white mass of hard tissue on his cheek which is firm in character, gives no pain, and does not come off with any ordinary means.

I thought that this was probably brought about by the patient biting his cheek, but I have not heard of or seen anything like it before, so I am taking the liberty to write to you for any information you can give me.—N. S., New York.

A.—I would say from your description that this condition is probably leukoplakia and that, if so, it could be caused either by repeated biting or by excessive smoking or both. It is important that you should determine which, if either, is the cause and correct it, as these conditions sometimes break down into cancer. If he is biting this cheek, reshape or remake the denture so that he cannot do so. If it is from smoking instruct him to not only stop smoking, but to discontinue the use of tobacco in any form.—V. C. SMEDLEY.

Grinding Teeth

Q.—What is being done to relieve patients of excessive gritting of teeth while sleeping? Will raising the bite relieve it to any extent?

One patient, a man of about 30, has been gritting his teeth for many years, his father doing the same, and many in his family also. Of course

his teeth are showing the wear; roentgenograms show some destruction of the alveolar processes. I have corrected the occlusion, which has not relieved the situation.

Any suggestions would be appreciated. The only one I have offered is a rubber splint, but told him I would look into his case further before advising any definite procedure.—D. L. M., Alabama.

A.—It is generally considered that grinding the teeth at night is a result of irritation, either of the general nervous system or locally. I suppose you have checked the mouth over carefully to see that it is perfectly healthy and that there is no interproximal decay. It would be wise to make roentgenograms of the entire mouth in a search for any causes of irritation. Then the occlusion should be carefully checked to see that there is no irritation from malocclusion. The next step would be for his physician to see that the general health condition is as good as it can be.

If you fail to accomplish any results by carrying out the foregoing suggestions, it might be wise to make a little vulcanite splint to fit over the teeth on the upper jaw and to be slipped on at night, providing a flat smooth occlusal plane for the teeth to slide on without interference. Such a splint can be held in place with two or more basket clasps. In some cases the tendency to grind the teeth has been entirely overcome by the wearing of such a splint at night for a few weeks. Others recommend a soft rubber splint.—V. C. SMEDLEY.

Numbness After Extraction

Q.—I extracted a lower left second molar about a month ago, using of

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course the mandibular injection. The patient still complains of a numbness in the lip. He states that he felt a little soreness for a day after the extraction. I have probed the gum around the anterior teeth with a dull instrument, and he says there is feeling in it, but still maintains the lip is numb, but that he can feel it if he pinches it very hard.

Assuming a slight injury to the nerve from the injection, did you ever hear of this condition before, in which there is normal sensation in all parts of the jaw, but in which the numbness still persists in the lip.—A. C. Y., New York.

A.—Injury to the inferior dental nerve may result in paresthesia, hyperesthesia, or anesthesia. The first two may vary in degree and extent of involvement.

You undoubtedly slightly injured the inferior dental nerve in taking out the second molar; the fibers to the lip being most seriously affected. This should clear up in a few weeks.—GEORGE R. WARNER.

Exposed Dentine

Q.—I am submitting a case of a young man who is having considerable pain in his mandibular molars on the left side. There are no cavities, but the enamel is worn down to the extent that the dentine is greatly exposed on all the occlusal surfaces.

I have treated these teeth for a period of over four weeks with no result. I have used silver nitrate, zinc chloride, heat and light. At times the pain is severe, and I will be grateful if you can inform me as to any treatment other than extraction that will bring relief. The teeth are sound.—R. M. R., Michigan.

A.—Nature is usually kinder than in the case presented; heavy wear on teeth is ordinarily compensated for by secondary den-

tine between the worn surface and the pulp.

However, we occasionally have a case like yours and we have resorted to the method of impregnating the dentine with silver nitrate under pressure. We block off the area with cotton rolls, saturate a piece of blotting paper with a saturated solution of silver nitrate, and lay it on the abraded surfaces. We then have the patient bite on this with all possible pressure. This pressure seems to have a greater obtunding effect than simply painting with silver nitrate or precipitating it.

If this treatment is not effective, you might resort to gold overlays. These overlays could be made with safety if the pulps are not abnormally large.—GEORGE R. WARNER.

Chalky Areas

Q.—A school boy of 15 presents white chalky areas along the cervical borders of the six upper anteriors. These areas literally peeled off during a cleaning, leaving a shallow, clean depression.

My problem is what is best to do here? Should all these areas, no matter how clean and shallow they are, be filled? Or is it safe to polish and leave them as they are?

What can I prescribe to help overcome this? A year ago there were no signs of the condition. He says he drinks a lot of milk, eats well balanced meals and gets a plenty of sleep.

Outside of this his teeth are in fine condition.

If you can help me I will be greatly obliged as I am anxious to arrest and overcome this condition if possible.—W. D. W., Massachusetts.

A.—The problem presented is indeed perplexing. In first considering the dietetic aspect of this

case, let me suggest that Vitamin D may be necessary to activate the proper absorption of the calcium contained in the milk. You should then see that he doesn't get much sugar. Because a "lot of milk" may be misleading, let's make it definite and insist on his having a minimum of a quart of milk per day. Citrus fruit juice is also helpful in these cases.

Now as to local treatment, if these areas are not actually caries and they are not soft, I think your idea of polishing them and watching them is quite all right, but, of course, it will be necessary for the boy to keep them scrupulously clean. If you instruct him in the Charters' method of tooth brushing, it will be possible for him to keep these areas clean. You can then inspect them every month or two and if they start to soften you can then fill them.—

GEORGE R. WARNER.

Sensitive Ridges

Q.—I have a patient for whom I extracted six upper and six lower anterior teeth August 3, 1935, and inserted full dentures immediately after the extractions. Since then the crest of the lower ridge is still sensi-

tive when he bites anything in the least hard. I wonder if you have ever heard of any other such case, and if so, if you can tell me what to do to correct this condition.

I have another patient who has been wearing full upper and lower dentures for about two years, but about every two or three months a sore spot develops on the periphery. Otherwise she has perfect comfort with her dentures. Could you give me any information on this?—G. J. D., Alabama.

A.—I would suggest, in Case I that you rebase this denture, using the Neil rebasing technique, which directs the pressure on the sides or flanges of the ridge as a saddle rests on a horse's back, avoiding any pressure, or at least any heavy pressure on the crest of the ridge.

In Case II the development of these sores under the periphery of this patient's dentures are probably caused by a gradual shrinkage of the ridges with consequent excess pressure on the periphery. I simply trim these for relief of pressure as they develop until settling is sufficient to justify rebasing, and then rebase, or preferably make a new or duplicate set.—V. C. SMEDLEY.